North East **LHIN**

Annual Report 2009-2010

Ontario
Local Health Integration Network

North East LHIN Region

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Message from the Board Chair and CEO

The NE LHIN is pleased to present its 2009/2010 Annual Report. In addition to providing a statistical health profile of the people who live in Northeastern Ontario, this report describes our process of community engagement. We recognize that behind every statistic is a person and these pages highlight tangible examples of the collaborative efforts made to ensure that health care is people care.

Peter Vaudry
Interim Chair

In 2009/10, our patient-focused work was done in partnership with our more than 200 health service providers, communities and citizens to ensure quality health care through fewer doors. We are proud to highlight our achievements including:

- Publication of our 2010-2013 *Integrated Health Service Plan* which was the result of engagement sessions with hundreds of people from across our region.
- Implementation of 49 *Aging at Home* initiatives which aim to keep our seniors in the comfort of their own homes longer with the services they need to stay independent.
- Creation of community steering groups to lead efforts on relieving ALC pressures in Sudbury, North Bay, Parry Sound and Sault Ste. Marie.
- Development of eHealth projects to help streamline health care delivery through technology-enabled initiatives.
- Completion of negotiations with 26 hospitals for the *Hospital Service Accountability Agreement (H-SAA)* extensions.

Louise Paquette
CEO

- Further engagement with our Aboriginal/First Nation/Métis people through our Local Aboriginal Health Committee (LAHC) and monitoring access to health care services for Francophone citizens.
- Strengthening partnerships with the Board Chairs and CEOs of our region's four large hospitals, the North East Community Care Access Centre and the Northeast Mental Health Centre through regular working group meetings and the commitment to develop a *Regional Home First Strategy*.

Changing a complex system such as health care cannot be done single-handedly – it will take the collective effort of many. Recognizing that solutions are best achieved through an integrated approach, the NE LHIN will continue to work in partnership with stakeholders across the region. Our commitment to make local investments in local priorities through local decision-making for the people of Northeastern Ontario remains steadfast and strong.

Peter Vaudry

Peter Vaudry
Interim Chair

Louise Paquette

Louise Paquette
Chief Executive Officer

Welcome to the NE LHIN

NE LHIN Vision and Mission

Health & wellness for all... through an innovative, sustainable and accountable system.

Values

Listen	*Our intention: You will be heard.*
Integrity	*Responsible and accountable for living our values.*
Proactive	*Anticipate needs and opportunities and act appropriately.*
Equity	*Opportunity for health and wellness for all.*
Serve	*Include Northeastern Ontario geographic, cultural, demographic and linguistic health and wellness needs in all activities.*

Population and Health Profile

The *Demographic, Socioeconomic, and Population Health Profile* published by the NE LHIN provides helpful insight into the people of Northeastern Ontario.

Our region is vast and spans approximately 400,000 square kilometres with more than 570,000 people. Over one third of our population lives in rural areas (40% compared to 15% provincially), and approximately 60% live in the four large urban centres of Greater Sudbury, Sault Ste. Marie, North Bay, and Timmins.

Our region's population is dispersed with 1.4 people per square kilometre, compared to the provincial average of 14 people/km^2. The population of Northeastern Ontario has decreased slightly by about 1%, compared to a provincial growth rate of nearly 9% since the 2001 Census.

The NE LHIN region is culturally diverse. Almost one-quarter of the people living in Northeastern Ontario are Francophone, compared to less than 5% in Ontario. Aboriginal, First Nation and Métis people make up about 10% of the population compared to less than 2% across the province.

Northeastern Ontario is home to a higher population of seniors at 17% verses 14% provincially. Within 20 years, the number of seniors living in Northeastern Ontario is expected to increase to 30%. In addition, there are more than 25,000 people age 65+ living alone in the NE LHIN, of which 19% are male and 40% female.

The Ministry of Health and Long-Term Care estimates that the prevalence of diabetes in people 18 years of age and over is 12.1% in Northeastern Ontario compared to 10.3% in the province. It is estimated that

the rate of diabetes in the national Aboriginal population is at least three times higher than for the non-Aboriginal population.

In order to effectively manage the vast region of this part of the province, the NE LHIN geography is broken down into seven planning areas: Manitoulin-Sudbury, Algoma, Nipissing, Cochrane, Temiskaming, James and Hudson Bay Coasts and Parry Sound. In addition to the population and geographic size differences, there are also demographic variations within planning areas, including:

- The Francophone population varies from 3% in the Parry Sound planning area to 51% in the Cochrane planning area;
- While more than 95% of the James and Hudson Bay Coast population is Aboriginal, First Nation or Métis, the proportion of Aboriginal, First Nation or Métis population varies from 6% to 11% in the remaining six planning areas;
- The proportion of population aged 65 and over varies from 14% in the Cochrane planning area compared to 21% in the Parry Sound planning area.

Population by NE LHIN Planning Area

Manitoulin-Sudbury	35%
Algoma	21%
Nipissing	15%
Cochrane	14%
Temiskaming	6%
James and Hudson Bay Coasts	1%
Parry Sound	17%

Overall, relative to the province, the North East has a higher:

- percentage of the population with Aboriginal identity
- percentage of Francophones
- proportion of older people
- percentage of lone parent families
- percentage of daily or occasional smokers and exposure to second hand smoke
- percentage of adults who are obese or overweight
- prevalence of self-reported activity limitations, arthritis/rheumatism, high blood pressure, diabetes, and asthma
- mortality rates for all causes combined, and for many specific disease categories such as circulatory system diseases, cancer and injuries

... and a lower:

- rate of population growth
- percentage of people with a secondary school certificate or post-secondary education
- percentage of immigrants and visible minorities
- percentage of people with a regular medical doctor or contact with a medical doctor in the last year
- percentage of people living in urban communities
- life expectancy, and
- percentage of people reporting very good or excellent health.

Statistics such as these play a large role in shaping the delivery of health care and the NE LHIN's mandate to work in partnership with the region's more than 200 health service providers to plan, fund and integrate.

NE LHIN Board of Directors

All Local Health Integration Networks are governed by an appointed Board of Directors. Each Board member is appointed by an Order-in-Council.

The NE LHIN Board of Directors have regular open board meetings in communities all across the region which allow Directors to meet with the people and health service providers they serve.

Three standing committees report directly to the Board, including: Governance, Audit and the Health Professionals Advisory Committee (HPAC).

Members of the NE LHIN Board 2009/10

Peter Vaudry
Interim Chair
Algoma Planning Area
(May 17, 2006 to May 31, 2011)

Marc Dumont
Timiskaming Planning Area
(May 17, 2006 to June 16, 2010)

Randy Kapashesit
James & Hudson Bay Coast Planning Area
(September 20, 2006 to September 19, 2012)

Leah Welk
Parry Sound Planning Area
(September 24, 2008 to September 2011)

Dr. Ian Cowan
Nipissing Planning Area
(February 10, 2010 to February 9, 2013)

Manitoulin & North Shore Planning Area
Interviews Completed

Sudbury Planning Area
Interviews Completed

Cochrane Planning Area
Recruitment Underway

Ministry-LHIN Accountability Agreement (MLAA)

The Ministry-LHIN Accountability Agreement (MLAA) defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the NE LHIN in the delivery of local health care programs and services. The MLAA establishes a mutual understanding between the Ministry and the LHIN and outlines performance indicators within a pre-defined period of time.

North East LHIN MLAA Performance Indicators 2009/2010

Performance Indicator	LHIN 2009/10 Starting Point	LHIN 2009/10 Performance Target	Most Recent Quarter 2009/10	Annual Results	LHIN Met Target – Within Corridor YES/NO
90th Percentile Wait Times for Cancer Surgery [1]	55	50	46	51	YES
90th Percentile Wait Times for Cardiac By-Pass Procedures	N/A	N/A	78	49	N/A
90th Percentile Wait Times for Cataract Surgery [1]	130	130	112	115	YES
90th Percentile Wait Times for Hip Replacement [1]	371	320	393	386	NO
90th Percentile Wait Times for Knee Replacement [1]	423	320	403	382	NO
90th Percentile Wait Times for Diagnostic MRI Scan [1]	73	69	94	88	NO
90th Percentile Wait Times for Diagnostic CT Scan [1]	29	28	33	29	YES
Median Wait Time to Long-Term Care Home Placement – All Placements [21]	141	135	151	133	YES
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution [22]	27.60%	17.00%	26.33%	26.43%	NO
Portion of Admitted patients treated within the LOS target of ≤ 8 hours [1]	60.00%	64.00%	53.83%	58.98%	YES
Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III [1]	92.00%	95.00%	86.90%	89.41%	YES
Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours [1]	90.00%	91.00%	86.83%	88.38%	YES

NOTES:

[1] FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from April 2009 to March 2010.

[21] LTCH Placement Indicator: - FY 2009/10 LHIN Annual Results = Actual Annual Performance Value from April 2009 to March. 2010.

[22] ALC Indicator: - Q4 %ALC days is estimated based on Q1, Q2 & Q3 2009/10 data. Fiscal year 2009/10 LHIN annual results are also estimated based on Q1-Q4 2009/10 data.

Report on MLAA Performance Indicators

At the end of 2009/10, the NE LHIN was able to achieve eight of the twelve performance indicators identified in its MLAA.

The wait time target of 69 days for MRI procedures was not achieved. The NE LHIN's annual performance of 88 days was due to the reduction in MRI incremental volumes in 2009/10. Hospitals reduced their MRI hours of operation in order to stay within their funding envelopes.

The wait time target of 320 days for hip and knee replacements was not achieved. While an improvement in knee wait times was seen at the beginning of the year, the NE LHIN was above the provincial target of 182 days for both hip and knee surgery. The NE LHIN ended 2009/10 with a wait time for knee replacement surgery of 386 days and 382 days for hip replacement. Two of the most significant factors that had an impact on hip and knee surgeries were: (1) the increase in number of alternate level of care (ALC) patients in hospital acute care beds which resulted in cancellations of surgeries due to lack of available beds; and (2) physician recruitment challenges across the region.

Although the NE LHIN did not achieve the targets for hip and knee replacements, the hospitals in the region were able to successfully complete all of their hip and knee wait time volumes. The NE LHIN was successful in hiring new orthopedic surgeons in Parry Sound, Timmins and Sudbury. Sudbury and Parry Sound also implemented a Joint Assessment Centre. The goal of the centre is to streamline the process between time of referral to surgery. In the next year, the NE LHIN's other wait time hospitals will also be implementing a joint assessment centre.

The percentage of ALC days target of 17% was not achieved. During 2009/10, the percentage of ALC days* in NE LHIN hospitals was 26.43% as compared to the provincial target of 9.46%. The NE LHIN experienced a slight decrease in ALC days from the starting point of 27.6%. During this period, many of the Aging at Home strategies were more fully implemented. The NE LHIN continues to struggle with the lack of available long-term care beds, supportive housing units and community-based services available. The lack of community supports impedes a hospital's ability to discharge patients into a more appropriate setting so that they can get the right care in the right place.

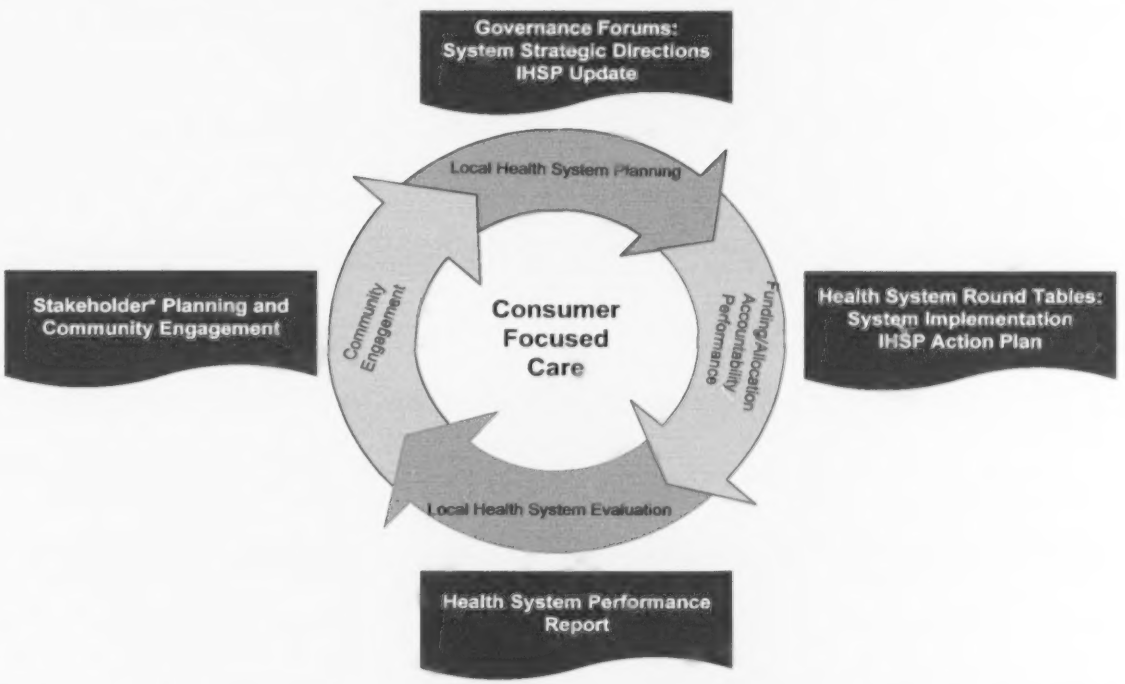
**Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment but remains in hospital due to a lack of supportive housing, long-term care home beds or home support services.*

Community Engagement Activities

The purpose of community engagement is to hear from the users of our health care system. Through our regular engagement activities, we are able to receive information on how community members perceive their health care system is meeting their needs. Collectively, this information informs the NE LHIN on how to best plan, fund and integrate health care within Northeastern Ontario.

The NE LHIN's *Community Engagement Strategy* provides a framework to actively engage, empower and mobilize communities, stakeholders and the public in planning for an improved health care system. It also addresses and reflects the specific cultural needs and linguistic characteristics of the Francophone and Aboriginal/First Nation/Métis people within our region.

The NE LHIN *System Planning and Implementation Cycle* was established to ensure that all stakeholders were included in the process of identifying system level priorities and providing opportunities for implementation of strategic directions.



All aspects of this collaborative community engagement and planning approach have been integrated into the NE LHIN's planning and business cycle. This allows relevant information and feedback to be captured in a timely manner. As identified in the diagram above, all stakeholders are included in one of the following settings:

I. Stakeholder/Community Groups: **Recommending system improvements**

- Communities, health managers, policy makers, health professions, academic institutions

II. Governance Forums: **Setting System Directions**

- Board members from LHIN-funded health service providers

III. System Implementation: **Implementing Governance Directions**

- Senior leadership from health provider and partner organizations

IV. Health System Evaluations: **Evaluating System Performance**

- Consumer surveys, performance evaluations

This collaborative approach is carried out under the framework entitled ***Towards Unity for Health (TUFH)*** as developed by the World Health Organization. This framework expresses the shared will of multiple partners to shape a sustainable health service based on people's needs. It is founded on the assumption that a coordinated and integrated approach is better than any other to improve quality, equity, relevance and cost-effectiveness in health. It speaks to the importance of engaging key partners/stakeholders in order to establish a sustainable, people-based health service in line with values of quality, equity, relevance and cost-effectiveness.

In 2009/2010, the North East LHIN continued to seek out opportunities to engage with our health care community partners, boards, consumers and other allied professionals, and representatives of our diverse cultural groups.

Stakeholder/Community Groups – Ongoing community engagement activities contribute to recommendations for system improvements. Regular community engagement is held with the following identified NE LHIN stakeholders: communities, health managers, policy makers, health professionals, and academic institutions.

Governance Forums – This year, the NE LHIN governance forum focused on the development and roll-out of the new three-year Integrated Health Service Plan and the priorities within it that were born out of extensive community engagement. In addition, several sessions were held with representatives of the NE LHIN Board of Directors and governance from health service provider organizations across the region. Discussions and actions arising out of these discussions centered on the need for both governance and operational levels of organizations to work towards the common goal of a more patient-focused health care system within Northeastern Ontario.

Health System Round Tables – As a result of an evaluation conducted in the summer of 2009, the Health System Round Tables were retired in early 2010 so that NE LHIN staff could concentrate their efforts on engaging with community partners as part of a project management process. Local ALC planning groups, as well as other pre-existing community planning groups continue to identify gaps within each planning area and speak with a collective voice on the health care needs within their region.

Health System Evaluation – The actions of the NE LHIN are evaluated through the delivery of our Integrated Health Service Plan, consumer surveys and our MLAA performance indicators.

Community Engagement With Our Aboriginal/First Nation/Métis People

In 2009/10, the terms of reference for the NE LHIN's Local Aboriginal Health Committee (LAHC) were completed. The LAHC provides advice to the NE LHIN in order to effectively move forward in partnership with the 10% of the Northeastern Ontario population who are Aboriginal/First Nation/Métis. The LAHC membership includes individuals from across the NE LHIN region. Subcommittees are formed from time to time in order to work on specific projects and actively fulfill the LAHC's mandate.

Additional activity within the Aboriginal/First Nation/Métis file in 2009/10 is outlined below.

Health Status and Environmental Scan – Started in 2010, this scan will be essential in helping to correct health information deficits and enhance effective health planning. The scan will provide an inventory of potential health information and research partners who can be engaged to begin the process to correct the long-standing health information deficits in evidenced-based Aboriginal information.

Mental Health and Addictions Framework – Started in 2010, this framework will align with provincial and federal programs to better meet the needs of NE LHIN Aboriginal communities. It will provide culturally appropriate and evidence-based sustainable options for enhanced service delivery structures to improve access and quality of mental health and addiction care for Aboriginal/First Nation/Métis people.

Weeneebayko Area Health Authority Framework Agreement (WAHIFA) - On August 31, 2007, a tri-party agreement (Weeneebayko Area Health Integration Framework Agreement) was signed by the provincial and federal governments and local leaders with the goal of helping to improve the health of the James Bay Aboriginal communities by paving the way for the Weeneebayko Area Health Authority (WAHA). The agreement has enabled the process to amalgamate the federal Weeneebayko General Hospital and the provincial James Bay General Hospital.

The NE LHIN provides support and leadership for the integration of health services and hospitals as per the WAHIFA. An agreement was reached on November 27, 2009 regarding the process for moving forward to implement WAHIFA. All parties agreed that the steps will include a governance led process.

2009/10 NE LHIN engagement activities with Aboriginal/First Nation/ Métis people

Two dialogue sessions were held with Aboriginal/First Nation/Métis partners in Timmins and Sudbury to review the NE LHIN's draft 2010-2013 Integrated Health Service Plan (IHSP). The dialogues were attended by sixty participants who agreed that Aboriginal/First Nation/Métis is an important stand-alone priority of the NE LHIN's IHSP and it should be measured within each of the remaining priorities.

Aging At Home Strategy – In 2009/10, the NE LHIN promoted and funded programs that enhanced the delivery of services for elderly people within the Aboriginal/First Nation/Métis communities, including nursing and homemaking services, personal support services, and geriatric services, among others.

Engaging with our Aboriginal, First Nation and Métis partners – (left to right) Beverly Nahwegahbow, Gloria Daybutch, Sheila Nigarobe, Karen Pine Cheechoo.

Community Engagement With Our Francophone Population

The NE LHIN continues to make progress in engaging Francophone stakeholders in the planning, integrating and monitoring of French language services. A focus of this past year was effective engagement with Francophone stakeholders for the purpose of validating the priorities in the 2010-2013

IHSP. On September 22, a Forum for Francophones was held with more than 50 people attending at approximately 10 sites across the region.

The results of this engagement highlighted the need for an integrated approach to the delivery of French Language Health Services (FLHS) across the designated areas of Northeastern Ontario. The NE LHIN is committed to demonstrating that French language services have been integrated into all IHSP priorities and that they are an integral part of the overall service delivery system. As a means of working towards this goal, the NE LHIN developed a FLHS policy, which was approved by the Board of Directors to serve as a guide in moving FLHS practices and activities forward.

In January 2010, the Ministry of Health and Long-term Care announced that French Language Health Planning Entities will be selected by July 1, 2010. As per the legislation, these entities will advise the LHINs on significant issues for Francophones to ensure that their needs are taken into consideration in LHIN planning activities. In the North, there will be one French Language Health Planning Entity that will work with both the NE and the NW LHIN.

In January 2010, a web page on French language services was also developed and included on the NE LHIN's web site to increase awareness of FLHS and the requirements of the *French Language Services Act*.

A major achievement for the NE LHIN with respect to FLHS, includes an accountability reporting tool that is part of all service accountability agreements with health service providers. This year, the NE LHIN monitored progress in hospital and multi-sector services towards the achievement of French Language Services (FLS) targets. A baseline indicator was also determined for the long-term care sector.

These activities were done in collaboration with the Northern Team of French Language Health Services. In February 2010, the Ministry of Health and Long-Term Care confirmed the transfer of Regional French Language Health Services to LHINs. Details are being finalized and the transfer will occur in 2010.

The NE LHIN will continue to strive for improvement in the quality and accessibility of FLHS; empower communities and engage communities in FLHS awareness.

Integrated Health Service Plan (IHSP)

An IHSP is essentially a LHIN strategic plan that guides the actions, programs and projects of a LHIN over a three year time period.

The NE LHIN published its first IHSP in December, 2006. It outlined seven priorities that were a reflection of the health care needs of people living in Northeastern Ontario. These priorities included: Aboriginal Health Services; Chronic Disease Prevention Management; Information and Communication

Technology System and Information Management; French Language Health Services; Health Human Resource Needs; Primary Care Reform; and Reduced Wait Times.

Progress on these priorities continued in 2009/10 and is summarized below.

Aboriginal Health Services -- In addition to working with the Local Aboriginal Health Committee (LAHC), the NE LHIN continued its efforts to formalize internal and external relationships, planning structures and processes for Aboriginal/First Nation/Métis engagement. These efforts helped to ensure meaningful input into NE LHIN decision making and correcting health information deficits for effective health planning. The NE LHIN continued as a key partner in facilitating progress with the formation of the Weeneebayko Area Health Authority (WAHA).

Chronic Disease Prevention and Management -- The NE LHIN focused its efforts on the implementation of the provincial diabetes strategy. Through the work of the Diabetes Management Steering Committee, in November, 2009 the NE LHIN announced diabetes team expansions in six locations across the region.

Information and Communication Technology System and Information Management -- The NE LHIN undertook several large eHealth projects in the past year. In 2009, the former eHealth project management office, shared by the NE and NW LHIN was moved to each of the respective LHINs. The excellent eHealth leadership from NE LHIN stakeholders has been a key success factor for the implementation of eHealth projects, such as: integrated services pilot project, ALC resource matching and referral project, electronic medical records and network management services. The NE LHIN was identified as an early adopter of the rollout of the provincial eHealth Strategy and has been involved in provincial eHealth priorities of diabetes management, medication management, e-physician and eHealth readiness.

French Language Health Services -- The NE LHIN continued to move forward with French Language Service activities. The main focus of this past year was to identify all health service providers located in designated areas of the North East. As a designated or identified organization, a health service provider must demonstrate how its Francophone population is being served. The NE LHIN also remained committed to working collaboratively with providers to ensure engagement activities were established for Francophone stakeholders. In addition the NE LHIN developed a policy that addresses the specific needs of our Francophone population.

Health Human Resource Needs -- The NE LHIN formalized a Health Human Resources Steering Committee. This committee is responsible for providing system-wide leadership on the development of a North East Ontario Health Human Resources Plan. This plan will be aligned with local, cultural and language related health human resource issues.

Primary Care Reform -- The priority of primary care will be addressed through the NE LHIN's work on chronic disease with an initial focus on diabetes management.

Reduced Wait Times – The NE LHIN's Wait Time Advisory Panel Work Group continued to meet quarterly to monitor wait times across the region and to provide advice on a range of matters related to addressing challenges and opportunities in meeting our LHIN's wait time targets. In addition, the Surgical Optimization Study steering committee began implementation of their extensive report which was published early in the 2009 fiscal year.

2010-2013 Integrated Health Service Plan (IHSP)

A refresh of the initial IHSP began in March 2009. Engagement activities were held between April and October in order to receive input on the development of the NE LHIN's second IHSP. An array of engagement activities to confirm and re-affirm NE LHIN priorities were held, including: open houses, forums, online chat rooms, teleconferences, video-conferences, dialogues, surveys, and questionnaires. More than 350 people participated.

Following months of community engagement, the NE LHIN released its second IHSP on November 30th, 2009. It outlined nine health care priorities that will focus the work of the NE LHIN over the next three years, including:

- **Aboriginal / First Nation / Métis Health Services**
- **Addiction and Mental Health Services**
- **Aging at Home**
- **Alternate Level of Care Strategies and Solutions**
- **Diabetes Care**
- **Emergency Department Wait Times**
- **French Language Health Services – An Integrated Approach**
- **Health Human Resources**
- **Optimize Surgical Services**

These priorities are not independent. They interconnect and together will help to ensure the long-term sustainability of our health care system while allowing greater access to quality care in North East Ontario. The implementation of these priorities will be approached through innovations in information and communications technology and electronic processes – eHealth.

It is evident that one of the overarching directions of the NE LHIN is not noted in this list of priorities - ***integration***. Rather, integration is an approach that will be included in our collective work. It is a shared responsibility. The only way the NE LHIN region can witness improved coordination within the local health care system is through greater collaboration among all partners.

NE LHIN Chief Executive Officer, Louise Paquette (left) speaks with Faye Naveau about geriatric services in Northeastern Ontario.

Integration Activities

The North East LHIN **Integration Strategy** details how the NE LHIN encourages and supports changes in health services that:

- enhance access to, and quality of, health services;
- improve individual and population health outcomes;
- improve the overall patient experience within the health system by reducing gaps and duplications; and
- realize greater efficiencies through the most effective use of available resources.

In 2009, the NE LHIN approved the allocation of close to $500,000 for ten integration projects across the region. These projects were selected from a number of proposals received from health service providers and include:

- **Cassellholme, East Nipissing District Home for the Aged**
  Identifying senior's needs and care pathways as noted in the NE LHIN Seniors Housing study.

- **Algoma Health System Planning Table**
  With a reduction to inpatient mental health beds at the new hospital, this project focused on program integration to offset the reduction of inpatient capacity.

- **North Eastern Ontario Rehabilitation Network (NEORN)**
  Focusing on the development of an integrated rehabilitation network for the region.

- **Northeast Regional Oncology Services Integration**
  Complimenting the NE LHIN Surgical Optimization Study, this project involves the development of a Regional Cancer Treatment Services Strategic Plan, as well as a detailed design of an integrated oncology IT strategy.

- **Cochrane Planning Area Strategic Planning Initiative**
  This project focuses on developing a strategic plan across all sectors within the planning area.

- **Prevention and Management of Chronic Diseases for Sault Ste. Marie**
  Developing a framework for the provision of care, around patient groupings, in line with the NE LHIN's integrated care pathways.

- **James Bay & Hudson Coast Bridge to Mental Wellness**
  Enhancing the planning, management and delivery of mental health programs for the James Bay & Hudson Coast, beginning with central intake and referral.

- **Lakeland Community Initiative**
  Furthering the Seniors Housing Report at the local level and developing an integrated service plan for senior services.

- **Nipissing Partnership**
  Furthering integration initiatives within the Nipissing planning related to ALC, this partnership includes: North Bay General Hospital, Cassellholme/Castle Arms, West Nipissing General Hospital, Mattawa General Hospital and the Northeast Mental Heath Centre.

- **Sault Ste. Marie Community Health Care Planning Framework**
  Creating a comprehensive vision and plan for the local health system given the current challenges being faced at Sault Area Hospital and the city of Sault Ste. Marie.

- **Mnaadmodzawin Health Services Inc. and M'Chigeeng First Nation**
  The divestment of long-term care funding for both communities to allow for increased coordination of services by decreasing travel time for nurses and increasing service hours.

  Le Club d'Age d'Or Alidor and Aide aux Seniors de Sudbury
  Transfer and integration of social and congregate dining program from Le Club d'Age d'Or Alidor to Aide aux Seniors, with no changes to services, activities will continue to promote health and wellness through social activities based on the needs of recipients.

In addition, in 2009 the NE LHIN Board of Directors approved the following voluntary integrations:

- Region-wide diagnostic imaging repository services for North East, North West and Champlain LHIN hospitals.

- Nipissing integration of the rehabilitation resources into the North Bay General Hospital.

- Hôpital régional de Sudbury Regional Hospital (HRSRH) and St. Michael's Hospital (Toronto) and the establishment of a region-wide model of collaborative service delivery and enhance access to tertiary trauma care for severely injured patients of NE Ontario whose needs exceed the resources available at HRSRH.

- One-Kids Place (OKP) and the North East CCAC and integrated pediatric care delivery for the School Health Support Service program in Nipissing and Parry Sound Planning Areas.

NE LHIN Initiatives to Support Provincial Priorities to Improve the Local Health Care System

Alternate Level of Care (ALC)

ALC refers to those patients, often elderly, who occupy a hospital bed long after their acute care treatment is completed because there is no place for them to go, for example – no long-term care home bed, supportive housing unit, or home care support for them to convalesce safely at home, to name a few.

The NE LHIN provides funding to local Red Cross offices to offer services such as transportation that allow seniors to stay independent and at home longer.

Northeastern Ontario has the highest rate of Alternate Level of Care (ALC) patients in our hospital's acute care beds at 31% (according to an Ontario Hospital Association survey in February 2010). 17% of the

people living in Northeastern Ontario are age 65 and over and this number is expected to increase to 30% by 2030.

High ALC rates are an indication that our health care system needs realigning. ALC patients place pressure on a hospital, ultimately leading to gridlock – less people being discharged than being admitted. These pressures cause longer wait times in our emergency rooms, fewer available beds for acute care and surgeries, and an uncomfortable feeling for family members and friends of a patient who want, and deserve, the best setting possible for their loved one.

It is clear that no one organization or individual will solve the long-standing and complex issue of ALC. The NE LHIN will continue to work in partnership with health service providers and community leaders across the region with the collective goal of fewer ALC patients in our hospital acute care beds, seniors receiving the care they need in the most appropriate setting, and more home care services available for people who could age-in-place longer with the proper assistance they need to help them manage their day.

In 2009/10, the NE LHIN made seniors' assisted living a priority for the third year of the Aging at Home strategy, facilitate community ALC steering groups in Sudbury, Parry Sound, Sault Ste. Marie and North Bay to help develop solutions to ALC pressures, and continued to work in partnership with local health service providers to bring ALC rates down. Much work in this area remains to be done and work will need to continue in earnest to bring about positive change in this long-standing and complex health care issue.

Emergency Department and Alternate Level of Care

Provincially, the ED/ALC Strategy has three clearly defined goals to address the current system challenges:

1) Reduce Emergency Department Demand
2) Increase Emergency Department Capacity and Performance
3) Faster Discharge for ALC Patients

In support of the first two goals, the NE LHIN has introduced initiatives in communities and hospitals such as increased falls prevention programming, geriatric case management, Identification of Seniors at Risk (ISAR) screening tool, Geriatric Emergency Management (GEM) nurses and nurse-led outreach teams in long-term care homes.

In early 2010, the NE LHIN established a North East ED Network. This acts as a coordinating and oversight mechanism for planning and program implementation activities related to emergency department services and systems in the region. The Network will support the implementation of the ED component of the ED/ALC Strategy, the development and implementation of strategies to address Health Human Resource requirements in EDs, and provide advice to the NE LHIN regarding Emergency Department resources across hospitals in Northeastern Ontario.

The NE LHIN is one of the top performing LHINs in the province with respect to ED wait times (being at or above provincial targets and performance). Nonetheless, improvements are possible particularly for times to inpatient admission from EDs. This will be achieved mainly through reducing ALC patients who are in acute care beds.

Analysis of LHIN Operational Performance

During the course of the year, the NE LHIN experienced many changes. Our inaugural Chair finished her term in June, 2009 and our new CEO Louise Paquette joined the organization on March 1, 2010.

Responsibility for eHeatlh initiatives within the region moved under the NE LHIN umbrella and four additional staff joined the organization in the late spring of 2009.

As of April 1, 2010, the NE LHIN staff complement was 27 full-time employees.

The combined skills of our staff reflect expertise in Aboriginal/First Nation/Métis health planning, Francophone health planning, and integration within the remote and rural geography of North East Ontario, data collection and analysis, community engagement, financial processes and negotiations, and communications.

The NE LHIN managed its responsibilities with a balanced budget in 2009/2010. With a region that spans 400,000 square kilometers and is home to more than 570,000 people, travel is a mainstay for NE LHIN staff and Board members. Staff travel extensively to meet with health service providers and consumers, and this past year increases in travel costs were attributed to the community engagement sessions held in conjunction with the 2010-2013 IHSP. As well, Board Directors travel extensively throughout the region to build partnerships with governance colleagues, engage with local stakeholders and participate in open board meetings held in communities across the region.

New Hôpital régional de Sudbury Regional Hospital. Opened in April, 2010.

New hospital in North Bay set to open in January, 2011.

New Sault Ste. Marie Area Hospital set to open in March, 2011.

Financial Statements

Financial statements of

North East Local Health Integration Network

March 31, 2010

North East Local Health Integration Network

March 31, 2010

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Auditors' Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the statement of financial position of the North East Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of operations, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the North East Local Health Integration Network as at March 31, 2010 and the results of its operations, changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 7, 2010

Member of
Deloitte Touche Tohmatsu

North East Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**698,735**	968,385
Due from the LHIN Shared Services Office (Note 3)	**4,969**	-
Due from MOHLTC-Other	**235,000**	-
Due from MOHLTC-Health Service Providers ("HSP")	**4,113,341**	3,701,600
	5,052,045	4,669,985
Liabilities		
Accounts payable and accrued liabilities	**641,712**	817,949
Due to MOHLTC (10b)	**296,992**	128,332
Due to the LHIN Shared Services Office (Note 3)	-	22,104
Due to Health Service Providers ("HSP")	**4,113,341**	3,701,600
Deferred capital contributions (Note 4)	**215,190**	213,966
	5,267,235	4,883,951
Net debt	**215,190**	213,966
Non-financial assets		
Capital assets (Note 5)	**215,190**	213,966
Accumulated surplus	-	-

Approved by the Board

Peter Vaudry Director

Leah Welk Director

North East Local Health Integration Network

Statement of operations
year ended March 31, 2010

	Budget (unaudited) (Note 6)	2010 Actual	2009 Actual
	$	$	$
Revenues			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,168,875,000**	**1,240,203,544**	1,169,655,493
Operations of LHIN	**4,832,335**	**4,684,155**	4,796,665
e-Health (Note 9a)	**600,000**	**600,000**	600,000
e-Health Project Funding (Note 9b)	-	**200,000**	-
Emergency Department Lead (Note 9c)	-	**60,000**	75,000
Aboriginal Engagement (Note 9d)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund (Note 9e)	**193,500**	**238,874**	45,374
Emergency Room/Alternate Level of Care (Note 9f)	-	**100,000**	33,300
Diabetes Strategy (Note 9g)	-	**65,000**	51,000
Diabetes: Self-Management (Note 9h)	-	**35,000**	-
Amortization of deferred capital contributions (Note 4)	**210,454**	**243,602**	210,454
	1,174,811,289	**1,246,530,175**	1,175,567,286
Expenses			
Transfer payments to HSPs (Note 7)	**1,168,875,000**	**1,240,203,544**	1,169,655,493
General and administrative (Note 8)	**4,832,335**	**4,679,829**	4,796,665
e-Health (Note 9a)	**600,000**	**596,734**	534,131
e-Health Project Funding (Note 9b)	-	**200,000**	-
Emergency Department Lead (Note 9c)	-	**60,000**	60,000
Aboriginal Engagement (Note 9d)	**100,000**	**100,000**	99,035
Aboriginal Health Transfer Fund (Note 9e)	**193,500**	**58,632**	-
Emergency Room/Alternate Level of Care (Note 9f)	-	**100,000**	32,728
Diabetes Strategy (Note 9g)	-	**65,000**	50,448
Diabetes: Self-Management (Note 9h)	-	**8,880**	-
Amortization of capital assets	**210,454**	**243,602**	210,454
	1,174,811,289	**1,246,316,141**	1,175,438,954
Annual surplus before repayable to MOHLTC	-	**214,034**	128,332
Funding repayable to MOHLTC (Note 10a)	-	**(214,034)**	(128,332)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

North East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2010

	2010	2009
	$	$
Annual surplus		
Acquisition of tangible capital assets	(244,826)	(35,670)
Amortization of tangible capital assets	243,602	210,454
Decrease (increase) in net debt	(1,224)	174,784
Opening net debt	(213,966)	(388,750)
Closing net debt	(215,190)	(213,966)

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus		-
Items not affecting cash		
Amortization of capital assets	**243,602**	210,454
Amortization of deferred capital contributions (Note 4)	**(243,602)**	(210,454)
Changes in non-cash working capital		
Increase (decrease) in due to/from the LHIN Shared Services Office	**(27,073)**	14,151
Increase in due from MOHLTC-Other	**(235,000)**	-
Increase in due from MOHLTC-Health Service Providers	**(411,741)**	(2,014,890)
(Decrease) increase in accounts payable and accrued liabilities	**(176,237)**	(274,527)
Increase in due to MOHLTC	**168,660**	61,686
Increase in due to Health Service Providers	**411,741**	2,014,890
	(269,650)	(198,690)
Investing transactions		
Acquisition of capital assets	**(244,826)**	(35,670)
Financing transactions		
Increase in deferred capital contributions (Note 4)	**244,826**	35,670
Net decrease in cash	**(269,650)**	(198,690)
Cash, beginning of year	**968,385**	1,167,075
Cash, end of year	**698,735**	968,385

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2010.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to

the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the LHIN Collaborative (LHINC) are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs, are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO/LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO/LHINC. This is all done pursuant to the agreement the LSSO/LHINC has with all the LHINs.

4. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**213,966**	388,750
Capital contributions received	**244,826**	35,670
Amortization	**(243,602)**	(210,454)
Balance, end of year	**215,190**	213,966

5. Capital assets

			2010	2009
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Furniture and fixtures	**70,404**	**65,006**	**5,398**	19,479
Computer equipment	**96,622**	**87,657**	**8,965**	29,124
Leasehold improvements	**966,025**	**765,198**	**200,827**	165,363
	1,133,051	**917,861**	**215,190**	213,966

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,240,203,544 is made up of the following:

	$
Initial HSP Funding budget	1,168,875,000
Adjustment due to announcements made during the year	71,328,544
Total HSP Funding budget	1,240,203,544

The total operating budget of $6,327,856 is made up of the following:

	$
Initial budget	5,725,835
Additional funding received during the year	602,021
Total budget	6,327,856

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,240,203,544 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2010	2009
	$	$
Operation of Hospitals	787,852,105	735,395,697
Grants to compensate for Municipal Taxation - Public Hospitals	254,475	249,825
Long Term Care Homes	177,584,058	168,778,614
Community Care Access Centres	100,772,313	93,802,009
Community Support Services	23,232,856	21,398,759
Acquired Brain Injury	1,741,573	1,263,094
Assisted Living Services in Supportive Housing	9,908,082	8,069,412
Community Health Centres	14,053,035	8,569,291
Community Mental Health	48,266,691	47,495,109
Substance Abuse & Problem Gambing	19,576,342	19,424,774
Specialty Psychiatric Hospitals	56,946,864	65,193,759
Grants to compensate for Municipal Taxation - Psychiatric Hospitals	15,150	15,150
	1,240,203,544	1,169,655,493

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2010, an amount of $4,113,341 (2009-$3,701,600) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

8. General and administrative expenses

The Statement of Financial Activities presents the expenses by function; the following classifies these same expenses by object:

	2010	2009
	$	$
Salaries and wages	2,421,825	2,404,290
HOOPP	222,485	254,296
Other benefits	285,762	251,173
Staff travel	193,788	245,695
Governance travel	83,021	68,463
Communications	83,200	91,240
Accommodation	161,681	160,409
Advertising	37,171	54,668
Banking	5	25
Consulting fees	234,161	539,596
Equipment rentals	17,236	20,044
Board Chair per diems	67,008	73,605
Other Governance per diems	52,898	55,970
Insurance	15,930	15,930
LHIN Shared Services Office	362,715	300,000
LHIN Collaborative	12,285	-
Other meeting expenses	33,919	32,031
Other governance expenses	11,403	29,441
Printing and translation	61,627	73,748
Staff development	71,084	36,446
IT equipment	74,972	37,117
Office supplies and equipment	71,055	45,119
Other	104,598	7,359
	4,679,829	4,796,665

9. a) e-Health expense

The E-Health office of the Ministry of Health and Long-Term Care provided $600,000 to the LHIN. The LHIN hired four permanent full-time staff to run a Project Management Office related to E-Health. In addition to covering the staff costs, the LHIN also incurred costs related to projects this group is responsible for. The total amount of expenses the LHIN incurred related to E-Health was $596,734.

b) e-Health Project Funding

The E-Health office of the Ministry of Health and Long-Term Care provided $200,000 to the LHIN related to the Initial Planning Activities for the Alternate Level of Care Resource Matching and Referral Project. A contract was setup between the LHIN and the North Bay General Hospital to support this project. In 2010 the LHIN incurred expenses of $200,000 related to this project.

c) Emergency Department Lead (ED Lead)

The Ministry of Health and Long Term Care announced they would be providing the LHIN an additional $75,000 in one-time funding to (a) pay the LHIN ED Lead $5,000 per month as well as (b) money to reimburse the LHIN ED Lead for any expenses. In March of this year, the Ministry of Health and Long Term Care recovered $15,000 as the LHIN was projecting a surplus. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2010 are $60,000.

d) Aboriginal Engagement

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations with the North East LHIN. The total amount of expenses paid using this funding was $100,000.

e) Aboriginal Health Transfer Funding (AHTF)

The Ministry of Health and Long Term Care provided an additional $193,500 in one-time funding for AHTF Adaption projects that were submitted for funding by the LHIN. Also, a formal request to have $45,374 from 2009 carried forward into 2010 was approved by the Ministry of Health and Long Term Care. The LHIN spend a total of $58,632 in 2010 and another formal request has been made to carry the surplus funds into 2011.

f) Emergency Room/Alternate Level of Care

The Ministry of Health and Long Term Care provided $100,000 in one-time funding to help the LHIN in supporting the North East ER/ALC Performance Lead, this amount was spent in full.

g) Diabetes Strategy

The Ministry of Health and Long Term Care provided $75,000 in one-time funding to help the LHIN in supporting the Ontario Diabetes Strategy. The total amount of expenses paid using this funding was $65,000. The Ministry of Health and Long Term Care recovered the $10,000 surplus in March 2010.

h) Diabetes: Self-management

The Ministry of Health and Long Term Care provided $35,000 in one-time funding to help the LHIN in supporting the implementation and the Self-Management Capacity Building Initiative. The total amount of expenses paid using this funding in 2010 was $8,800.

10. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC is made up of the following components:

	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	1,240,203,544	1,240,203,544	-
LHIN operations	4,684,155	4,679,829	4,326
Amortization of capital assets	243,602	243,602	-
E-Health	600,000	596,734	3,266
E-Health Project Funding	200,000	200,000	-
Emergency Department Lead	60,000	60,000	-
Aboriginal Engagement	100,000	100,000	-
Aboriginal Health Transfer Fund	238,874	58,632	180,242
Emergency Room/Alternate Level of Care	100,000	100,000	-
Diabetes Strategy	65,000	65,000	-
Diabetes: Self-Management	35,000	8,800	26,200
	1,246,530,175	1,246,316,141	214,034

The amount due to the MOHLTC is made up of the following components:

	2010	2009
	$	$
Opening balance	128,332	66,646
Funding recovered by the MOHLTC	-	(66,646)
Funding allowed to be carried into 2010	(45,374)	-
Funding repayable to the MOHLTC (Note 10A)	214,034	128,332
Closing balance	296,992	128,332

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 24 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2010 was $222,485 (2009 - $254,296) for current service costs and is included as an expense in the Statement of Operations. The last actuarial valuation was completed for the plan as at December 31, 2009. At that time the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Future lease payments aggregates are $871,419 and include the following amounts payable over the next five years:

2011	171,527
2012	168,072
2013	167,349
2014	163,488
2015	160,786

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2010 the LHIN had signed Accountability Agreements with all Hospitals and Community Agencies for the next two years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

14. Comparative Figures

Certain comparative figures have been reclassified to conform to the current year's presentation.